REPORT FORM INSTRUCTIONS

The report form must be typed or clearly printed in black ink.

Reporting Facility: Record the complete address of your facility or physician's office.

Patient Name: Record the full name.

Patient's Address at Diagnosis: Record the permanent home address at the time of diagnosis; not a temporary relocation for treatment. Street address takes priority over post office box number.

Patient's Current Address: Record the patient's current address if different than the address at diagnosis. A temporary relocation address or post office box number may be recorded in this field.

Date of 1st Contact with Patient for this Cancer: Record in MM/DD/YYYY format the date the patient was first seen for this cancer at your office or clinic.

Patient's Industry: Record the primary type of activity carried on by the business or industry where the patient was employed for most of his/her life prior to the diagnosis of cancer.

Occupation: Record the patient's usual occupation of work performed during most of the patient's life prior to the diagnosis of cancer. Do not record retired.

Chart Number: Record the patient's chart number.

Social Security Number: Record the patient's social security number. Do not record a spouse's number.

Date of Birth: Record in MM/DD/YYYY format.

Does Patient Have a History of Other Cancer? : If the patient has a history of cancer, record the type and date when they were diagnosed. For example, Yes, prostate, 12/92.

Race: Check the appropriate box; if American Indian, if known record the tribe.

Hispanic: Check if the patient considers himself or herself to be of Hispanic origin.

Sex: Check the appropriate box.

Date of Diagnosis: Record in MM/DD/YYYY format. The date of diagnosis refers to the first diagnosis of this tumor by any recognized medical practitioner. If unknown, record "99/99/9999". If Diagnosed Elsewhere: If the patient was diagnosed elsewhere, record the facility name and location. If unknown, record "unk".

Primary Site and Subsite: Record the site of origin of the tumor. It is important to identify the primary site and not a metastatic site. Example: breast; lung. Record the subsite if known. Example: upper outer quadrant of the breast; lower lobe of the lung. If unknown, record "unk".

Tumor Size: Record size of the tumor in millimeters. Be sure to record the tumor size from the primary site and not a metastatic site. Tumor size for multiple tumors within a single primary is to be coded to the size of the largest tumor. If unknown, record "unk".

Cell Type: Record the histology. Example: mucinous adenocarcinoma; infiltrating ductal carcinoma. If unknown, record "unk".

Grade: Check the appropriate box for tumor grade. For leukemia and lymphoma check the appropriate box for T-cell, B-cell (pre-B), Null (non T-non B), or not stated.

Extent at Diagnosis: Check the appropriate stage of tumor. Stage is not a follow-up item that is changed as the disease progresses; it concerns only the stage at time of diagnosis (within two months of diagnosis). Refer to the SEER Summary Staging Guide for further clarification. Use the following categories to determine the extent at diagnosis:

- •In Situ-Not progressed through the basement membrane of the organ involved.
- •Local-Limited to site of origin; progressed through the basement membrane but not beyond the walls of the organ involved.
- •Regional Extension-Direct extension to adjacent organs or tissues only.
- •Regional Lymph Nodes-Involvement of regional lymph nodes only.
- •Regional Extension and Nodal Involvement-Direct extension and involvement of regional lymph nodes.
- •Distant-Direct extension beyond adjacent organs or tissues, or metastases to distant sites or distant lymph nodes.
- •Unknown-No information is available to determine extent of disease.

Substantiate Extent At Diagnosis: Substantiate the extent of disease by writing a short explanation. For example, confined to breast, nodal and mets workup negative. This can be abbreviated as confined, nodal & mets wkup neg.

Distant Involvements at Time of Dx: If stage is distant at diagnosis, circle the site(s) that the cancer is distant to. For leukemia and multiple myeloma, leave blank.

Paired Organ: Check the appropriate organ involvement: Right; Left; Both; Unknown; or Not Applicable.

Diagnostic Confirmation: Check the most reliable method used in diagnosing this cancer. If available, attach copy of pathology report. The following guidelines are to be used to determine the method:

- •Histology-Microscopic diagnosis based upon specimens from biopsy, frozen section, and surgery.

•Cytology-Diagnosis based on microscopic examination of cells rather than tissue. Included are smears from sputum, bronchial washings, and brushings, etc.

•Clinical-Diagnosis made at surgical exploration or by use of an endoscope, but not supplemented with positive microscopy.

•X-ray-Radiological diagnosis (x-rays, scans) not microscopically confirmed.

•Unknown-Diagnosis method unknown.

Optional TNM: Refer to the AJCC Manual for Staging of Cancer to code the following items:

Basis: Refers to classification (clinical [C] or pathologic [P]).

T: Extent of the primary tumor

N: Regional lymph node metastasis

M: Distant metastasis

Stage Group: TNM categories are grouped into a stage.

Treatment: First course treatment includes the cancer directed treatment modalities given by clinicians at the time of diagnosis. In general, *first course therapy* includes cancer directed treatment received by the patient within the first four months after the initiation of therapy. For leukemia patients, the basic time period for first course is two months after the initiation of therapy. When recording treatment, write the type of treatment, the date the treatment was received or began, where performed, and residual tumor (e.g., none, microscopic or macroscopic residual). Record all first course treatment received. Do not record second course treatment.

Patient Status and Date: Check the current status: Alive; Dead. Record the date last seen or date of death in MM/DD/YYYY format.

Cancer Status: This refers to the patient's cancer status of this cancer at the date the patient was last known to be alive or dead. Check the appropriate box.

If Expired, Place of Death: If the patient is expired, record the place of death. If unknown, record "unk".

Cause of Death: If the patient is expired, record the cause of death. If unknown, record "unk".

Follow-Up Physician: List the physician who will be reexamining the patient for this cancer.

Second Physician: List any additional physicians who have treated or will treat the patient for this cancer.

Form Completed By: Record the full name of the person completing the form.

Date Completed: Record the date completed.